STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 000	INITIAL COMMENTS	F 000	Submission of a Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited. It is also not to be construed as an admission of interest against the facility Adminstrator or any employees, agents or other individual who draft or may be discussed in the Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

This report is the result of an unannounced Abbreviated Survey conducted at Emerald Care on October 28, 2013, October 31, 2013, and November 1, 2013. A sample of 5 residents was selected from a census of 71 residents. The sample included 3 current residents and the records of 2 former and/or discharged residents.

The following were complaints investigated as part of this survey:

#2886716
#2890566
#2888897
#2891696
#2901488
#2890496
#2891071
#2896556
#2894432
#2890210
#2900381

The survey was conducted by:
[redacted] R.N.

The survey team is from:
Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, District 1, Unit C
3611 River Road, Suite 200
Yakima, Washington 98902

Telephone (509) 225-2800
Fax: (509) 574-5597

Received
Yakima RCS
NOV 22 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael V. Hoa	Administrator	11/22/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Residential Care Services Date	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	See Page 2 A attached	

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F 225	Continued From page 2	F 225	See Page 3 A	

This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility failed to initiate an investigation and report to the appropriate entities in a timely manner, and prevent further abuse as required by 42 CFR 483.13(c)(2)-(4) following an allegation of abuse involving 1 of 2 sampled residents (#1). This deficient practice potentially resulted in further abuse to residents. Findings include:

Resident #1: Review of Progress Notes dated 10/12/13 revealed the resident was alert and oriented, and required staff assistance with activities of daily living.

Review of a facility investigation report dated 10/14/13 revealed on 10/12/13 (two days prior) at 5:30 p.m. the resident alleged Staff C (male Nursing Assistant (NA)) had made a sexually inappropriate statement to her after getting her a food snack. The investigation stated the resident had told a female NA what Staff C had said to her. The female NA then informed a Licensed Nurse who did come in and speak with the resident that same evening. The investigation report stated law enforcement and the state agency were notified on 10/14/13.

Review of Staff C's time card noted he continued to work the rest of the evening shift on 10/12, a full eight hour shift on 10/13, and 4.5 hours on 10/14/13, at which time he was sent home pending the results of the investigation.

An interview on 10/31/13 at 1:00 p.m. with Staff B

F225

The residents plan of care was updated	10/31/13
Resident #1 continues to be a 2 person care at all times. Now she will have only female caregivers assigned to her.	10/31/13 and ongoing
The LN in charge on 10/12/13 did investigate the reported allegation by the Resident #1. She (the LN) completed an interview with the 2nd caregiver (who was witness to the interaction of resident 1 and staff c) and came to the conclusion based on her initial investigation that the allegation was unfounded.	10/12/13
The LN in charge as well as all staff have been in-serviced on our policy and procedure of all alleged abuse (verbal or physical) or neglect.	10/14/13 and ongoing
Resident #1 was re-interviewed to ensure that she is feeling safe from all staff members	10/31/13
All other residents Plan of Care will be audited by the Resident Care Managers to ensure caregiver preferences have been met.	11/1/13 and ongoing
All Staff has been re-inserviced on the requirement of Mandatory reporting and the Purple Book (location for reference and contents).	10/26/13 and ongoing
Any allegations will be reported to the Administrator and Director of Nursing	11/1/13 and ongoing
The Director of Nursing Services will report to the Quality Assurance Committee	11/21/13 and ongoing
The Administrator will oversee	11/21/13 and ongoing

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F 225	Continued From page 3 (Social Services) noted the resident had informed her on 10/14/13 of the sexually inappropriate statement made to her by Staff C. The resident stated to her she was upset as she had talked with several staff members that weekend and nothing seemed to be done. Social Services stated administrative staff did not become aware of the allegation until 10/14/13. Despite an allegation of abuse on 10/12/13 by the resident regarding Staff C, staff failed to initiate an investigation; report the allegation to the Administrator, law enforcement, and the state agency; and prevent further potential abuse until 10/14/13 (two days following the allegation).	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to implement their policies/procedures for the reporting and initiation of an investigation, and protection of residents following an allegation of abuse involving 1 of 2 sampled residents (#1). In addition, the facility failed to ensure adequate screening was performed on 1 of 4 potential employees (Staff C). Failure to implement abuse prevention procedures in a timely manner left residents vulnerable to continued abuse. Findings include:	F 226	See Page 4 A	

226

Staff #C, a Nursing Assistant, Registered, completed an application and on that application and during his interview indicated that he had no other place of employment prior to Nursing Assistant Classes.	10/14/13 and ongoing
Personal references were obtained for Staff Member C	10/31/13
The LN as well as all staff have been in-serviced on our policy and procedure of all alleged abuse (verbal or physical) and/or neglect. To immediately remove staff for allegations until completion of investigation/law enforcement findings and Phase II of the investigation is complete.	10/31/13 and ongoing
All future Nursing Assistants, Registered, who have not been employed will have a high school teacher reference or a personal reference. In addition a reference will be obtained from the Nursing Assistant Program. We will also complete the task of checking NACES for scheduled testing dates	11/1/13 and on going
The Human Resource Director will in-service all staff, who hire staff, the facility Policy and Procedure of obtaining 2 references	11/7/13 and ongoing
The Staff Development Director will ensure 2 references are on file before scheduling the staff member for any shifts	11/28/13 and ongoing
All Staff have been re-inserviced on the requirement of Mandatory reporting and the Purple Book (location for reference and contents).	11/1/13 and ongoing
The Director of Nursing Services to monitor for compliance and report her findings to the Quality Assurance Committee	11/28/13 and ongoing
The Administrator will oversee	11/28/13 and ongoing

MH

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F 226	Continued From page 4 Review of the facility Abuse & Neglect Prevention policy/procedure stated the investigation must be initiated immediately upon the discovery of a resident with an allegation of abuse, and immediately reported to the Administrator/Director of Nursing, law enforcement, and state agency. In addition, the facility policy/procedure also stated that previous/current employers are contacted as a means of screening on all potential employees. Despite an allegation of abuse on 10/12/13 by Resident #1 regarding Staff C, staff failed to initiate an investigation, report the allegation to the Administrator, law enforcemnt, and the state agency; and prevent further potential abuse until 10/14/12 (two days following the allegation). Review of Staff C's (male Nursing Assistant named in allegation by Resident #1) personnel file revealed no references were contacted to ensure appropriate screening had been performed prior to hiring. An interview on 10/31/13 at 3:00 p.m. with Staff C revealed he had previously held jobs working in the field. Cross-refer to F225. The facility failed to inititate an investigation and report to the approrpaite entities in a timely manner, and prevent further abuse.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 5 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to develop a comprehensive care plan for 1 of 5 sampled residents reviewed (#1) for care planning. Following Resident #1 having an intimate encounter with a male visitor in her room there was no documented plan in place for staff to ensure the rights of Resident #1 and other residents. Findings include: During interviews on 10/31/13 at 10:35 a.m. with Staff B (Social Services) she stated a male visitor was in Resident #1's room this summer during the night shift. A Nursing Assistant had knocked on the door (which was closed). When she entered the room she found the cubicle curtain was drawn around the resident's bed. At that point a male visitor got off the resident's bed, grabbed his pants, and pulled them up. The resident's roommate was in the room at the time	F 279	See Page 6A	

279

The resident's plan of care was updated to reflect the preferences and need for private time with male visitor.	10/31/13
A new policy and procedure has been developed relating to requests for residents rights for accessing private intimate time.	11/21/13
The new policy will be shared with the Resident Council Members as well as all other Residents in the facility.	11/21/13 and ongoing
Any current residents who request private time for visitation with a family member or friend will have their plan of care updated by Social Service Department to reflect current and any possible future requests and directives to staff to follow the policy and procedure	11/28/13 and ongoing
The Staff Development Director will in-service all staff on the new Policy and Procedure related to visitation and privacy	11/22/13 and ongoing
Upon admission, Social Service/Quality of Life LN will address with residents and/or representative the facilities new Policy and Procedure.	11/22/13 and ongoing
The Resident Care Managers will ensure all preferences are care planned upon admission, change of condition and quarterly.	11/22/13 and ongoing
The Quality of Life Nurse will monitor for compliance and report to the Quality Assurance Committee her findings	11/22/13 and ongoing
The Director of Nursing Services will oversee	11/28/13 and ongoing

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F 279	Continued From page 6 of the incident and was "uncomfortable" about male visitors being in her room during the night. When the resident was questioned about what had taken place she stated the male visitor was giving her a back rub on her bed. Following the incident the resident had been instructed she no longer could have male visitors in her room with her roommate present, but could visit with them in the lobby or a private place. Staff B stated the resident, per assessment, had no cognitive deficits. Despite the above incident review of the resident's plan of care did not address the resident's need for intimacy, and there was no plan in place for staff to follow to ensure her rights and the rights of other residents.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and inteviews the facility failed to perform necessary assessments and facilitate timely care and treatment in response to changes in the condition of 1 of 3 sampled residents (#2) reviewed for changes in condition. This failed practice potentially resulted in a delay in medical treatment. Findings include:	F 309	See Page 7A	

309

Resident is no longer at the facility

Revision to the skin assessment policy to include guidelines to complete a comprehensive assessment that includes but not limited to; skin changes, pain and function and phase I of the investigation process.	11/21/13 and ongoing
The Team Leader/Treatment Nurse have be in-serviced on their new responsibilities related to the revised skin assessment policy (attached)	11/22/13 and ongoing
The new Medical Records Director, RN will monitor for compliance and report her findings to the Quality Assurance Committee	11/22/13 and ongoing
The Director of Nursing Services will monitor for compliance	11/22/13 and ongoing
The Administrator will oversee	11/22/13 and ongoing

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F 309	Continued From page 7	F 309		

Resident #2: Admitted to the facility with diagnoses which included dementia. Review of Progress Notes dated 9/24/13 revealed the resident utilized a front wheeled walker with ambulation and had a steady gait.

An interview with Staff A (Treatment Licensed Nurse) on 10/31/13 at 11:55 a.m. revealed a Nursing Assistant had asked her on 9/30/13 to examine the resident's right great toe due to changes in it. She stated she did so and noted the resident's toe was bruised and the edge of the nail bed was purple in color. When she questioned the resident if he was having any pain he indicated yes by opening his mouth and making a facial expession. She stated she reported her findngs to the charge nurse that same day (9/30/13).

Review of the resident's Medication Administration Record noted the resident received his routine [redacted] Arthritis on 9/30/13 (ordered twice daily), but did not receive any additional pain medication.

Despite significant changes in the resident's [redacted] toe there was no nursing assessment of the toe until the following day (10/1/13), at which time the physician was notified and orders received to obtain an x-ray, which revealed a fracture of the [redacted] toe.